SECTION 1

GENERAL

1.0. CONTRACTOR RESPONSIBILITY IN PROGRAM INTEGRITY

1.1. The contractor shall incorporate into its organizational management philosophy a published corporate strategy that underlines commitment to health care fraud detection and prevention that complies with 32 CFR 199.9. The strategy, developed and endorsed by corporate management, shall include maintaining a focus on increased health care fraud awareness, developing processes which identify fraud, aggressively referring health care fraud cases, assisting in the prosecution of the cases, and developing deterrents to health care fraud. Internal procedures shall be in place for all offices to provide potential fraud and abuse cases to the contractor's program integrity function.

1.2. Program integrity is a contractor responsibility to ensure that medically necessary services are provided only to eligible beneficiaries by licensed pharmacies under existing law, Regulation and TRICARE Management Activity (TMA) instructions. In carrying out this function, the contractor is required to apply all the standards and requirements addressed in this Attachment 11. The contractor shall have a program integrity function which shall perform the program integrity activities listed below and shall respond to requests and direction from the TMA, the Office of General Counsel and the Program Integrity Office.

1.3. The contractor shall develop and maintain those internal management controls necessary to prevent theft, embezzlement, fraud, or abuse of benefit funds. These controls shall be addressed in an annual letter of assurance submitted to the Contracting Officer. This letter shall be submitted within 60 calendar days of the end of the contractor's fiscal year. The letter shall address the contractor's internal audit procedures, and the findings of those internal audits. It shall identify any weaknesses and the corrective action taken to resolve those weaknesses.

1.4. The contractor shall conduct the following functional activities:

1.4.1. On-line manipulation and analyses of pharmaceutical data associated with type, frequency, and extent of services, to identify patterns of probable fraudulent or abusive practices by providers, pharmacies and/or beneficiaries. Commercial anti-fraud software designed for such purposes, or upon approval of the TMA, the contractor's own link-analysis program will be used. Software must be state-of-the-art and have the ability to use layered logic and artificial intelligence, to receive queries in English, to ask questions in English and to produce comprehensive fraud detection reports. The application must be on-line and accessible by the contractor's Program Integrity Unit fraud specialists and shall be used on a daily basis. TMA expects the contractor will identify a minimum of ten cases per year utilizing this software. Any cases identified and their disposition shall be included as an addendum to the fourth quarter Fraud and Abuse Summary Report. If development warrants, cases shall be referred to TMA.

1.4.2. Perform validation audits on statistical samples of claims for care provided by specific pharmacies. Perform audits of claims submitted by specific beneficiaries to verify services with the pharmacy. Transmit the audit and its health care database information via electronic media.

1.4.3. Provide technical and professional consultation and information concerning the delivery of health care services in the United States and the requirements of TRICARE for the submission, adjudication, and reimbursement of claims for health care services.

1.4.4. Identify and provide expert witnesses at Grand Jury proceedings, criminal and civil trials.

1.4.5. Provide requested documents as directed by the TMA Program Integrity Office or Office of General Counsel.

1.4.6. Evaluate the effectiveness of prepayment screens and postpayment detection reports and initiate appropriate changes. Maintain the supporting documentation for the changes for two years unless the change is mandated by TMA.

2.0. ROLES AND RESPONSIBILITIES OF COOPERATING COMPONENTS

2.1. TRICARE Management Activity/TMA

The Director, TMA, and designees administer the TRICARE program in accordance with TRICARE law, Title 10, Chapter 55, United States Code, "Medical and Dental Care," 32 CFR 199, and other applicable laws, regulations, directives and instructions.

2.2. Program Integrity Office, TMA

The Program Integrity Office is the centralized administrative hub for fraud and abuse activities worldwide. The Office is responsible for developing policies and procedures regarding prevention, detection, investigation and control of TRICARE fraud, waste and program abuse, monitoring contractor program integrity activities, coordinating with DoD and external investigative agencies and initiating administrative remedies as required.

2.3. Office of General Counsel, TMA

The Office of General Counsel is responsible for providing legal counsel and legal services to TMA. It is the principal point of contact on all legal matters involving the Department of Justice (DOJ) and its Federal Bureau of Investigation. This office serves as DOJ's primary contact point in civil litigation involving benefit funds, and in preparing for litigation or pursuant to litigation, may make direct requests to TMA offices, principally the Program Integrity Office, and contractors for information and records. The Office of General Counsel is responsible for actions pursued under the Program Fraud Civil Remedies Act (PFCRA) and, in developing or pursuing a PFCRA case, may request information, data, and records from TMA offices and contractors. Settlements that affect the agency (e.g., civil settlement involving a monetary compromise, a pharmacy's TRICARE status, compromise of waiver of any sanction) must be coordinated with and approved by TMA, Office of General Counsel, or designee.

2.4. Department of Defense Inspector General (DoDIG)

The DoDIG has the responsibility to conduct, supervise, monitor, and initiate investigations relating to fraud within the DoD. This authority specifically includes TMA, its employees, contractors and subcontractors. This authority is not limited by the type of contract which has been entered into by the Director, TMA. All contractor, managed care, consultant, service, and other types of contracts are subject to the audit, investigation and evaluation authority of the DoDIG.

2.5. Defense Criminal Investigative Service of the DoDIG (DCIS)

The DCIS is responsible for all fraud investigations involving the Secretary of Defense, the Office of the Joint Chiefs of Staff, the Defense Agencies (including the TMA), and any other fraud investigation deemed appropriate by the DoDIG or designated representative. The DCIS has primary investigative jurisdiction for cases concerning alleged fraud. This includes cases that may involve alleged fraud by retired service members and their family members, and managed care cases (to include network pharmacies).

2.6. Military Criminal Investigation Organizations (MCIOs)

The MCIOs include the United States Army Criminal Investigative Division (USACID), Naval Investigative Service (NIS), United States Air Force Office of Special Investigations (AFOSI), United States Coast Guard Investigations and Health and Human Services Inspector General's Office (for the United States Public Health Service). The MCIOs have jurisdiction to investigate cases concerning alleged fraud by Active Duty military service members and their family members who have received health care services.

2.7. Defense Contract Audit Agency (DCAA)

Upon request, the DCAA provides audit assistance to the DCIS and MCIOs.

2.8. Department of Justice (DOJ) and United States Attorneys' Offices (USAO)

The DOJ, acting through its Civil and Criminal Divisions, and the USAO have responsibility for litigation and prosecution of cases involving violation of the civil and criminal laws of the United States.

2.9. Federal Bureau of Investigation (FBI)

The FBI is the principal investigative arm of the DOJ. It has primary responsibility for investigating federal employee bribery and conflict of interest cases and other violations of Federal law except those that have been assigned by law or otherwise to another Federal agency. It has the authority to investigate Federal agencies, Federal contractors, and Federal program fraud such as the submission of fraudulent TRICARE claims.

3.0. COORDINATION AND SUPPORT: OTHER CONTRACTORS AND EXTERNAL AGENCIES

3.1. Contractor Coordination with other TRICARE Contractors

Contractors shall coordinate their activities with other TRICARE contractors since potential fraud or abuse involving a pharmacy or beneficiary could have a direct effect on payments made by another contractor. The TMA Program Integrity Office shall be informed in the case report of these contacts and findings. Findings of potential fraud or abuse by another contractor shall be reported to the TMA Program Integrity Office by the contractor which initiated the investigation.

3.2. Contractor Coordination and Support with DOJ, U.S. Attorney's Office and Investigative Agencies

3.2.1. DOJ has jurisdiction for civil action. Requests for information related to civil action must be referred to the TMA Office of General Counsel, with a copy to the TMA Program Integrity Office.

3.2.2. The DoDIG has jurisdiction over all cases involving suspected fraud or other criminal activity under TRICARE. Requests for information by the criminal investigative arm of the DoDIG, DCIS, shall be referred to the TMA Program Integrity Office. Contractor contact by any other investigative agency, e.g., FBI, MCIOs, etc., shall also be reported immediately to the TMA Program Integrity Office. The contractor may not release any documents or copies of documents, conduct audits, etc., at the request of any individual or agency without direction from the TMA Program Integrity Office or the TMA Office of General Counsel.

3.2.3. The contractor shall provide investigative and prosecutive support, at the direction of the TMA Program Integrity Office or Office of General Counsel, by downloading claims data in no less than dBase III+ format on a CD-ROM. Other documentation to be provided may include the original or copies of claims, original or copies of checks (front and back), or any other relevant information, as requested. The contractor shall have dedicated personnel and equipment available to meet the timeliness requirement of ten calendar days for retrieval, transmission, and/or mailing of the information.

3.2.4. The contractor shall ensure compliance with the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Reorganization Act, Public Law 102-321 (July 10, 1992) and implementing regulations including 42 CFR Part 2, when data requested includes services related to substance abuse.

3.2.5. The contractor must identify and provide for expert witnesses at Grand Jury hearings, criminal trials and civil and administrative cases. An expert witness is an individual having acquired a special skill or knowledge through training or experience on a subject being discussed. This could be a professional person (medical doctor, dentist, etc.) or a technical person (lab/x-ray technician, ADP person, etc.) A prosecutor or defense attorney may request that a witness be declared an "expert witness" based on their knowledge, such as someone from the policy department or the contractor's claims processing section. Travel and per diem costs of witnesses subpoenaed by DOJ will be paid by DOJ in accordance with Federal guidelines.

3.2.6. The contractor must provide technical and professional consultation concerning the operations and benefits of TRICARE to investigative agencies, DOJ or U.S. Attorney's Office for both criminal and civil cases.

3.3. Contacts by Suspects or Their Legal Representative

The contractor shall refer all contacts with the contractor by the suspect or his/her legal representative (personal, letter or telephone) to the TMA Office of General Counsel.

3.4. Coordination with Private Business and Other Government Contractors

Contractors shall implement procedures for and coordinate potential fraud or abuse cases with the program integrity units of their private business and other Government contractors, such as Medicare or Medicaid.

SECTION 2

CASE DEVELOPMENT AND ACTION

1.0. INITIAL REVIEW

The contractor shall have an operational procedure for developing cases of potential fraud or abuse which includes, at a minimum, the following actions. When a contractor receives an allegation of fraud or abuse or when a potentially fraudulent situation is first identified by contractor staff, the contractor shall initially review the case to eliminate obvious billing or claims/encounter processing errors. This review shall be restricted to an examination of the internal processing of the claims to identify possible sources of any error. A TRICARE Fraud and Abuse Report will be completed to establish a case file (Addendum A, Figure A-1).

1.1. Claims processing error identified: If it is established that a complaint received directly from a beneficiary or network pharmacy was due to a claims processing error, the error shall be corrected. The contractor may then close out the case and notify the complainant, subject to disclosure of information guidelines (Privacy Act), of their findings. The contractor shall clearly document the reason for the case closure.

1.2. Inability to Determine Error - Possibility of Fraud or Abuse: After possible internal processing errors have been ruled out, the contractor shall control the case on a management reporting system for fraud and abuse cases and proceed to develop the case. The contractor, shall identify when the aberrant billings started (such as, when the claims were initially denied as noncovered).

2.0. INTERNAL INVESTIGATION

2.1. All Abuse Cases And Fraud Cases Under $10,000

The contractor's required actions will normally include: education, warning of the penalty for filing false claims, recoupment, and prepayment monitoring. A record of the action taken by the contractor must be completed and retained. For recoupment procedures, see Section J, Attachment 3, “Claims Adjustments and Recoupments.” All monies paid by previous TRICARE contractors and recouped by the current contractor will be refunded to the TMA Chief, Finance and Accounting Office. Cases determined on review to support allegations of fraud but are under $10,000, should not be referred to TMA. The contractor shall send pharmacies educational letters advising them to curtail their aberrant billing practices and provide guidance on how to bill correctly. These letters should be sent certified mail return receipt. Recoupment action should be taken on any monies paid in error. Re-evaluate the pharmacies in six months to a year to determine if the aberrant billing practices have been discontinued. If they have not, follow the procedures for referring the case to TMA. A critical piece of evidence to include in the referral is the educational letter with the signed receipt.

2.1.1. *The contractor shall screen drug claims for potential overutilization and substance abuse. If a potential drug abuse situation is identified by a private physician, a physician reviewer in the course of business for the contractor, or a physician in a hospital setting, as representing an addictive state in the beneficiary, the beneficiary shall be placed on 100% prepayment review. 32 CFR 199.4, precludes government cost-sharing of benefits to support or maintain potential drug abuse situations. This is true, whether or not the drugs are obtained by legal means and are otherwise eligible for benefit consideration under other circumstances. The contractor shall:*

- *Pend all claims for the beneficiary;*
- *Establish the necessity for the drugs and their appropriateness on the basis of diagnosis or definitive symptoms;*
- *Deny all related claims if a drug abuse situation does exist including office visits or emergency room visits if the purpose of the visit was to obtain drugs; and*
- *Reopen prior claims (most recent 12 months) for the beneficiary and review those claims to determine whether or not drug abuse existed at the time the earlier claims were paid. If drug abuse is ascertained for prior claims, recoupment action shall be taken for the erroneous payments.*

2.1.2. *The contractor shall request the beneficiary to select a physician, who will act as the primary care physician coordinating all care and making referrals when appropriate. For Prime enrollees, the contractor shall take action to manage the beneficiary's treatment as appropriate. The contractor shall not submit these cases to the TMA Program Integrity Office unless potential fraud is identified, such as altered prescriptions or drug receipts, or aberrant prescribing patterns by the physician. When appropriate, the contractor shall develop the case as stated below.*

NOTE: *Beneficiaries are entitled to benefits by law. Beneficiaries cannot be sanctioned to preclude them from seeking benefits for medical care which is appropriate and medically necessary.*

2.2. All Abuse Cases And Fraud Cases Of $10,000 Or More

The contractor or its representative shall not conduct personal interviews with beneficiaries, pharmacies or providers in developing the potential fraud / abuse case. Such interviews will be conducted, if necessary, by the appropriate Government investigative agency.

2.2.1. The contractor shall develop the case to determine the probable method of fraud / abuse and potential dollar value of the case, such as cases which involve an allegation that the pharmacy is billing for services not rendered, or the pharmacy is falsifying medical records. The contractor's review shall include all the pharmacy numbers used by that pharmacy. An audit shall be accomplished if there is evidence of possible fraud, e.g., repetitive occurrences of a pattern of abnormal billing.

2.2.1.1. If the case involves more than 50 claims within the most recent 24 months, a sample audit which is statistically valid, at a 90 percent confidence level, plus or minus ten percent with a 50% occurrence rate shall be randomly selected from a claims history arrayed in claim internal control number ascending order. The contractor must have the capacity to electronically generate sample sizes and random numbers using a Government approved

system. Addendum A provides guidance concerning selection of samples, calculating overpayments, testing the validity of the sample by calculation of the standard deviation of the sample(s) and standard error of the mean(s).

2.2.1.2. The audit findings must be reported in a clear and concise manner in an automated spreadsheet, accompanied by a description of the audit with summary information in quantifiable terms. The audit spreadsheets shall provide the criteria used for determination of overpayments, e.g., no entry, not a benefit. An analysis of the frequency of the occurrence of overpayments can lead to conclusions concerning further investigative actions. Other methods of analyses may be used concerning abusive practices.

2.2.1.3. If the case involves less than 50 claims within the most recent 24 months, audit the entire universe.

2.2.2. Cases of beneficiary eligibility fraud require the SSN to be flagged to prevent further claims from being processed or providing services by a network pharmacy. Develop and refer to TMA only those cases that involve more than a $25,000 loss to the government. Handle administratively those cases that involve less than a $25,000 loss to the government. Only at the direction of the Chief, TMA Program Integrity Office, with the concurrence of the TMA Office of General Counsel, will a pharmacy's or beneficiary's claims be indefinitely suspended from payment due to potential fraud. In this case, formal notification to the pharmacy or beneficiary by the contractor will occur (Figure A-4, Special Notice to Network Pharmacy When Pharmacy's Claims are Suspended, and Figure A-5, Special Notice to Beneficiary When Beneficiary's Claims are Suspended). The contractor, upon written request from the TMA Program Integrity Office, shall notify in writing the COR and the Health Benefits Advisors in close proximity to the network pharmacy. For those cases where a beneficiary submits a claim, or one is submitted on his or her behalf, which includes services involving a suspended network pharmacy, the contractor, under the guidance of the TMA Program Integrity Office, shall send a special and specific notice to the beneficiary (Figure A-6).

3.0. REFUND OR PAYMENT ACTIONS: TMA DIRECTION

3.1. If the contractor's investigation identifies potential fraud or abuse and involves an overpayment, the contractor shall not request a refund of the overpayment, except for eligibility cases where the loss is less than $25,000. The contractor shall obtain written instructions from the TMA Program Integrity Office prior to taking any adverse action, to preclude such action from interfering with the Government's investigation. At the TMA direction claims processing may be suspended.

3.2. If a suspect voluntarily remits a refund, the contractor shall forward the check to the TMA, Finance and Accounting Branch, along with an explanation and case identification. Photocopies of the remittance (check, money order, etc.) shall be made and placed in the case file of the suspect to maintain a complete record of all financial transactions related to the case. Such record (ADP printouts, manually developed financial transaction records, etc.) shall be retained by the contractor in the case file until the final disposition of the case.

4.0. FRAUD AND ABUSE CASE REFERRALS TO TMA

4.1. The contractor shall establish policies, procedures and organizational units for the purpose of preventing, detecting, developing, reporting and evaluating cases of suspected fraud and program abuse for referral to TMA. The contractor shall collect information on the effectiveness of its health care fraud detection and prevention programs by maintaining statistics on the costs of the fraud detection compared to the proportionate amount of health care funds recovered. Reports or a summary statement shall be submitted to the TMA Program Integrity Office quarterly with the fraud and abuse summary report.

4.2. The contractor shall refer all initially developed (i.e., clerical and / or processing errors have been ruled out and the case exceeds the exception provided in Section 2, paragraph 6.0.) allegations of potential fraud to the TMA Program Integrity Office within 30 calendar days of its determination of potential fraud and abuse, in accordance with Section 2, paragraph 6.0. The contractor shall not report fraud and abuse cases which are suspected of violating Federal law directly to the DCIS, MCIOs, FBI or any other investigative organization. All cases shall be reported to TMA Program Integrity Office in accordance with the procedures in this chapter.

4.3. The contractor shall not initiate recoupment action or take any other administrative action on a potential fraud and abuse case except as expressly provided in this chapter. Refer to the NOTE under Section 2, paragraph 5.9. and to Section 2, paragraph 6.0. These potential fraud and abuse cases shall be referred to TMA.

4.4. The contractor shall not respond to direct requests for documentation from investigative agencies. The contractor shall promptly notify the TMA Program Integrity Office of any requests made directly to the contractor. If the contractor responds directly to a request for documentation from an investigative agency, the costs of responding shall not be charged to the contract.

4.5. It is DoD policy that all employees, contractors and subcontractors shall cooperate fully with investigative agencies of the United States upon the direction of the TMA Program Integrity Office. All written requests for claims histories, medical and other records, correspondence, audits and other documentation shall be provided by the contractor. The contractor shall comply with requests for witnesses and technical support.

5.0. FRAUD AND ABUSE CASE REFERRAL CONTENT

The contractor shall submit the following information in duplicate when referring cases of potential fraud or program abuse. The case will contain a completed TRICARE Fraud and Abuse Report (TMA Form 435, Figure A-1).

5.1. Summarize the behavior which is suspected to be in violation of Federal law, regulation or policy; for example, billing for pharmaceuticals or supplies that were not provided, altering receipts or claim forms, duplicate billing, providing incorrect information when seeking prior authorization, etc. This shall include identifying specific facts that illustrate the pattern or summary conclusions.

5.2. Describe the individual or institution suspected of committing or attempting to commit the alleged wrongful behavior, including all appropriate information, such as the

beneficiary's name, sponsor's status and social security number, beneficiary's relationship to sponsor, pharmacy's identification number, address, telephone number, etc.

5.3. Describe how the alleged violation of Federal law, regulation or policy occurred, e.g., submitted probable false claims to the contractor through the U.S. Post Office or via electronic mail, altered checks, misrepresented the description and coding of services, falsified the name of the actual pharmacy dispensing the prescription, altering medical records, etc. Enclose copies of the claims, explanation of benefits forms, medical records, and other documents demonstrating the suspicious behavior. Enclose a history covering the most recent 24 month period in electronic media in dBase III+ format, on CD-ROM or hard copy. Hard copy histories are acceptable only for histories of less than 100 claims / encounters.

5.4. Describe how the suspicious behavior was uncovered, e.g., audit, prepayment screen, beneficiary or pharmacy complaint or tip, DoD Hotline, investigator notification, etc.

5.5. Estimate the number of claims, the length of time the suspicious behavior has occurred and of the Government's and Contractor's loss.

5.6. Describe the current status of claims or other requests submitted by the suspected pharmacy or beneficiary, i.e., regular development, processing and payment or denial, claims suspension, prepayment review, etc.

5.7. Describe and enclose a copy of any documents, such as any correspondence with the pharmacy or beneficiary and telephone conversation records. Provide a copy of all contractor audits on the suspected pharmacy or beneficiary. Describe any other facts that may establish a pattern of practice or indicate that the pharmacy or beneficiary intended to defraud the Government or the contractor. Include a copy of the supporting document(s).

5.8. Conduct, prepare and include a random sample validation audit of the most recent 24 month period that is statistically valid, of the claims against the medical or clinical records to determine the harm to the Government by identifying the method of the fraudulent action and the average overpayment per claim, extrapolated to the universe of claims from which the random sample was selected. A random audit should not be conducted if there is clear evidence of fraud and the individual would be alerted of an investigation by requests for records. If there is significant harm to the Government or the case develops into a significant fraud investigation, then there may be a need to do a statistical audit that covers more than a two year period.

5.9. All audits will include a summary spreadsheet that clearly identifies the audit parameters, the findings for each patient audited (or claim, depending on how the audit is set up), and totals all applicable columns. Each patient's claim(s) and supporting documentation shall be filed in a separate manila folder which clearly identifies, by last name, the patient and sponsor's Social Security Number. Each folder shall contain the contractor's individual audit sheet for those claims.

NOTE: In suspected cases of fraud / abuse, do not send an educational letter or attempt recoupment unless an exception is specifically permitted elsewhere in this chapter (e.g., violation of network agreement in reimbursement limitation, potential loss is less than $10,000). Administrative remedies can adversely impact civil or criminal prosecution of a case and are inappropriate if fraud is suspected.

6.0. CONTRACTOR ADMINISTRATIVE ACTION

6.1. Fraudulent and abusive practices are violations of the 32 CFR 199 or may constitute violations of the U.S. Criminal Code (Title 18).

- Investigations, either criminal, civil or administrative, are matters within the jurisdiction of the Federal Government. The United States reserves the right(s) to resolve any disputes with third parties over the submittal of false claims under TRICARE or claims that potentially may be false claims. The definition of "false claims" in the False Claims Act, 31 U.S.C. 3729, applies to this contract provision.

6.2. The contractor shall take administrative action under the following circumstances:

- The total number of claims involved is less than 25 and the total potential loss to the contractor or Government for the claims is less than $10,000.00. The time period for the claims involved is 12 or more months.

- The government has not provided written declination or taken any action on a case for 12 months after receipt from the contractor. The contractor shall contact the TMA Program Integrity Office to ensure the case is not under active investigation.

- The contractor has received a written declination from the Government for the case.

6.3. Administrative action may include:

- Referring the case to local or state investigations for referral to the district attorney or state attorney general.

- Initiating recoupment action.

- Placing the beneficiary or network pharmacy on prepayment review.

6.4. The TMA and the contractor will provide assistance to the local or state authorities in their investigation and prosecution of the case.

7.0. POSSIBLE FORGERY OF CHECK ENDORSEMENT

7.1. When the payee of a pharmacy benefits check alleges that the endorsement on the check was forged, the contractor shall immediately initiate reclamation proceedings to have its bank credit the amount of the forged check to the TRICARE account. This shall be accomplished as follows:

7.1.1. Affidavit Required

The contractor shall request the payee to submit an affidavit of the forgery. A supply of these forms can usually be obtained from the contractor's bank. In requesting the payee to complete the affidavit, the contractor shall explain to him or her that the issuance of

a replacement check is contingent upon timely return of the completed affidavit and TRICARE receiving a credit on the forged check.

7.1.2. Request for Credit

When the affidavit is received from the payee, the contractor shall forward it, along with the original of the allegedly forged check, to the contractor's bank with a request that the bank credit the amount of the forged check to the TRICARE account. Under the Uniform Commercial Code (UCC) generally adopted by all states, a bank is liable for cashing a forged check and must credit the payment back to the account upon which the check was drawn when the forged check affidavit, executed by the payee, is received.

7.1.3. Issuing a Replacement Check

When the bank sends notice it has credited the TRICARE account for the amount of the forged check, the contractor can issue a replacement check to the payee.

7.1.4. Cooperating in Investigation/Prosecution

The forgery of a contractor check is a violation of state law; it also may violate several statutes. However, it is generally more efficient for local authorities to handle such cases. Therefore, the contractor shall rely upon the bank for appropriate referral of the matter for investigation by state authorities. When requested to do so, the contractor shall cooperate with the state authorities in their investigating efforts. Questions concerning the release of information to state authorities in these cases shall be directed to TMA, Office of General Counsel.

7.1.5. Reporting to TMA and Other Contractor Actions

7.1.5.1. Cases involving unusual circumstances shall be reported immediately to TMA. Such circumstances might include a suspicion that the forgery involves contractor employee fraud or a pattern of forgery suggesting an organized effort. One time occurrence forgery cases shall be reported using the TMA Fraud and Abuse Report (TMA Form 435, Figure A-1).

7.1.5.2. The contractor is required to take timely action. While the UCC holds the bank strictly liable for cashing forged checks, the states have generally adopted statutes of limitation relieving the banks of liability for any reclamation action not initiated within a specified time. These time limits generally vary from one to three years. Therefore, it is essential that the contractor promptly act upon notice that a payee did not receive a check or upon notice of an alleged forgery.

SECTION 3

PREVENTION AND DETECTION

1.0. FRAUD AND ABUSE

1.1. Abuse is defined in 32 CFR 199.2 as:

> "...any practice that is inconsistent with accepted sound fiscal, business, or professional practice which results in a TRICARE claim, unnecessary costs, or TRICARE payment for services or supplies that are: (1) not within the concepts of medically necessary and appropriate care as defined in this Regulation, or (2) that fail to meet professionally recognized standards for health care providers. The term "abuse" includes deception or misrepresentation by a provider, or any person or entity acting on behalf of a provider in relation to a TRICARE claim."

The Regulation goes on to state that a pattern of inappropriate practice will normally be required to find that abuse has occurred unless a specific action is deemed gross and flagrant. Any practice or action that constitutes fraud as defined below would also be abuse.

1.2. Fraud is defined in the Regulation as:

> "...1) a deception or misrepresentation by a provider, beneficiary, sponsor, or any person acting on behalf of a provider, sponsor, or beneficiary with the knowledge (or who had reason to know or should have known) that the deception or misrepresentation could result in some unauthorized TRICARE benefit to self or some other person, or some unauthorized TRICARE payments, or 2) a claim that is false or fictitious, or includes or is supported by any written statement which asserts a material fact which is false or fictitious, or includes or is supported by any written statement that (a) omits a material fact and (b) is false or fictitious as a result of such omission and (c) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact. It is presumed that, if a deception or misrepresentation is established and a TRICARE claim is filed, the person responsible for the claim had the requisite knowledge. This presumption is rebuttable only by substantial evidence. It is further presumed that the provider of the services is responsible for the actions of all individuals who file a claim on behalf of the provider (for example, billing clerks); this presumption may only be rebutted by clear and convincing evidence."

2.0. CONTROLS, EDUCATION, TRAINING

2.1. Prevention and Detection of Fraudulent or Abusive Practices

The contractor shall establish procedures for the prevention and detection of fraudulent or abusive patterns and trends in billings by pharmacies and beneficiaries on a pre and postpayment basis. The key functions include, but are not limited to:

- Eligibility verifications for beneficiaries and pharmacies.
- Coordination of benefits.
- Prepayment utilization control as applied to program exclusions and limitations and detection and/or control of fraud and abuse.
- Application of utilization review and quality assurance standards, norms and criteria.
- Postpayment utilization review to detect fraud and/or abuse by either beneficiaries or pharmacies and to establish dollar loss to the Government.
- Application of security measures to protect against embezzlement or other dishonest acts by employees.
- Enforcement of conflict of interest provisions and dual compensation prohibitions.

2.2. Fraud and Abuse Education

2.2.1. The contractor shall establish and maintain a formal training program for all contractor personnel in the detection of potential fraud or abuse situations. This may be included as a specific segment of the contractor's regular training programs. (See Section J, Attachment 6). The contractor shall provide desk procedures to the staff which include methods for control of claims/encounters exhibiting unusual patterns of care, over or under utilization of services, or other practices which may indicate fraud or abuse and shall include specific criteria for referral of cases to professional or supervisory review concerning issues with patterns of care, abnormal utilization practices, or suspect billing practices.

2.2.2. The contractor shall establish a public education program addressed to beneficiaries and pharmacies which provides information about identified fraudulent or abusive practices and how individuals may identify and report such practices.

2.3. Beneficiary and Pharmacy Flags

The contractor must have the capability for automated flagging of specific pharmacies and TRICARE beneficiaries for prepayment review when fraud, over utilization or other abuses are known or suspected. If a network pharmacy is determined to be engaged in potential fraudulent practices, the contractor at its discretion, may terminate the pharmacy's network agreement. The contractor's actions shall be in a manner so as to not jeopardize the Government's investigation.

3.0. EXAMPLES OF FRAUD AND ABUSE SITUATIONS

3.1. TRICARE Beneficiary Eligibility Questionable

3.1.1. If there is reason to question the eligibility of a beneficiary and fraud is suspected, e.g., through correspondence, DEERS response, or contractor file data which raises some question about the eligibility of a beneficiary, the contractor shall immediately investigate internally to eliminate obvious clerical errors. If the internal investigation does not resolve the possibility of fraud, the contractor shall coordinate with the Pharmacy Data Transaction Service Customer Service Center to clarify the beneficiary's eligibility status.

3.1.2. In cases where eligibility fraud is evident, the contractor shall flag the beneficiary file to suspend all claims for services provided on / after the date eligibility reportedly ended. The beneficiary is not to be contacted or informed of the investigation. The contractor shall retain a copy of the cancelled check in the case file. If the beneficiary inquires about the claim(s), he or she will be informed that the claim requires review and he or she will be advised when processing is complete. The contractor shall establish procedures for control of these claims and for keeping them in a suspense status until the eligibility status has been established.

3.1.3. If the DEERS response indicates that the beneficiary is not eligible, the contractor shall research claims history for other erroneous claims from the date TRICARE eligibility ended. If the contractor's history does not date back far enough, request a history printout from TMA Program Integrity Office. The contractor shall report the circumstances to TMA Program Integrity Office in accordance with the procedures for case referrals.

3.2. Conflict of Interest; Federal Employees and Active Duty Military

3.2.1. Conflict of Interest

3.2.1.1. Conflict of interest includes any situation where an active duty member of the Uniformed Services (including a reserve member while on active duty, active duty for training, or inactive duty training) or civilian employee (which includes employees of the Veterans Administration) of the United States Government, through an official federal position has the apparent or actual opportunity to exert, directly or indirectly, any influence on the referral of beneficiaries to himself / herself or others with some potential for personal gain or the appearance of impropriety. Although individuals under contract to the Uniformed Services are not considered "employees," such individuals are subject to conflict of interest provisions by express terms of their contracts and, for purposes of the 32 CFR 199.9 may be considered to be involved in conflict of interest situations as a result of their contract positions. In any situation involving potential conflict of interest of a Uniformed Service employee, the Director, TMA, or a designee, may refer the case to the Uniformed Service concerned for review and action.

3.2.1.2. If such a referral is made, a report of the results of findings and action taken shall be submitted to the Director, TMA, within 90 days of receiving the referral, by the COR. TRICARE cost-sharing shall be denied on any claim in which a conflict of interest situation is found to exist.

3.2.2. Federal Employees and Active Duty Military

The Regulation prohibits active duty members of the Uniformed Services or employees (including part-time or intermittent), appointed in the civil service of the United States Government, from authorized TRICARE provider status. This prohibition applies to TRICARE payments for care furnished to TRICARE beneficiaries by active duty members of the Uniformed Services or civilian employees of the Government. The prohibition does not apply to individuals under contract to the Uniformed Services or the Government.

3.2.3. Exceptions

3.2.3.1. Reserves Generally Exempt

Conflict of interest provisions do not apply to medical personnel who are Reserve members of the Uniformed Services or who are employed by the Uniformed Services through personal services contracts, including contract surgeons. Although Reserve members, not on active duty, and personal service contract medical personnel are subject to certain conflict of interest provisions by express terms of their membership or contract with the Uniformed Services, resolution of any apparent conflict of interest issues which concern such medical personnel is the responsibility of the Uniformed Services, not the TMA. Reservists on active duty are not exempt during the period of their active duty commitment.

3.3. Cover-Ups in Coordination of Benefits

Coordination of benefits is a standard part of TRICARE claims processing requirements. Listed below are frequently overlooked common clues to the existence of another health plan.

- "Benefits Assigned" notation
- Large bills filed late
- Large credits
- Bills or statements that appear to have been altered
- Odd partial payments
- Other Carrier inquiries

3.4. Co-payment Collection

The 32 CFR 199.4. sets forth the financial liability of TRICARE beneficiaries for co-payments. This regulatory requirement is derived from the statutory requirements of 10 U.S.C. 1079 and 1086. The contractor shall ensure that network pharmacies collect applicable co-payments before dispensing any prescription.

SECTION 4

REPORTING

1.0. FRAUD AND ABUSE SUMMARY REPORT

The information from the case reports will be compiled and submitted to the TMA Program Integrity Office within 45 calendar days of the last day of each calendar quarter. The format and requirements for this quarterly report are provided at Figure *A-10.* Attach a listing of patient name and sponsor Social Security Number or pharmacy name and pharmacy NCPDP number(s), whichever is appropriate, to identify the referenced cases in the report that are found to be potential fraud / abuse cases. Also, include the potential fraud / abuse issue associated with each case.

2.0. SAVINGS REPORT

At least annually, the contractor shall report to the TMA Program Integrity Office the potential dollar amounts saved as a result of the activities / intervention of the anti-fraud / investigative units (e.g., disallowed services that otherwise would have been paid if the network pharmacy suspected of billing the program inappropriately had not been placed on prepayment review).

SECTION 5

PHARMACY EXCLUSIONS, SUSPENSIONS AND TERMINATIONS

1.0. SCOPE AND PURPOSE

1.1. This section specifies which individuals and entities may, or in some cases must, be excluded from the TRICARE program. It outlines the authority given to the Department of Health and Human Services / Office of Inspector General (DHHS / OIG) to impose exclusions from all Federal health care programs, including TRICARE. This section also outlines the TRICARE Management Activity (TMA) authority for exclusions and terminations. In addition, this section states the effect of exclusion, factors considered in determining the length of exclusion, and provisions governing notices, determinations, and appeals.

1.2. Service Points of Contact do not have the authority to overturn a TMA or DHHS exclusion.

2.0. PROVISIONS FOR EXCLUSIONS, SUSPENSIONS AND TERMINATIONS

2.1. Authority for Sanctioning a Pharmacy

2.1.1. 32 CFR 199.9

32 CFR 199.9 provides for administrative remedies available to TMA for pharmacy exclusions, suspensions, and / or terminations. The Director, TMA, or a designee, shall have the authority to exclude, suspend, and / or terminate a TRICARE Pharmacy.

2.1.2. Health Insurance Portability And Accountability Act (HIPAA) Of 1996, Public Law 104-191

HIPAA sets forth the DHHS / OIG's exclusion and civil money penalty authorities (CMP). HIPAA expanded the minimum mandatory exclusion authority; established minimum periods of exclusion; established a new permissive exclusion authority; and extended the application of CMP provisions to include all Federal health care programs. In addition, HIPAA strengthened and revised the DHHS / OIG's existing CMP authorities.

2.1.3. The Balanced Budget Act of 1997 (BBA)

The BBA fraud and abuse provisions serve to strengthen the DHHS / OIG's exclusion and CMP authority with respect to Federal health care programs. The BBA enables the DHHS / OIG to direct the imposition of exclusions from all Federal health care programs.

3.0. DHHS/OIG APPLICATION OF SANCTION AUTHORITY

3.1. Exclusions

3.1.1. Mandatory Exclusions

3.1.1.1. DHHS/OIG will exclude the following individuals or entities from participation in any Federal health care program:

- Felony conviction of program related crimes.
- Felony conviction related to patient abuse.
- Felony conviction relating to health care fraud.
- Felony conviction related to controlled substance.

3.1.1.2. DHHS/OIG authority for mandatory exclusion applies where the criminal offense on which the conviction is based took place after August 21, 1996, and the conviction took place after January 1, 1997. DHHS/OIG authority does not apply if both conditions are not met. In these cases, TMA Program Integrity Office must initiate action to exclude.

3.1.1.3. Mandatory exclusions initiated by DHHS/OIG are for a minimum of five years. Aggravating factors may be considered as a basis for lengthening the period of exclusion.

3.1.2. Permissive Exclusions

3.1.2.1. DHHS/OIG may exclude the following individuals or entities from participation in any Federal health care program:

- Misdemeanor conviction related to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct.
- Misdemeanor conviction related to obstruction of an investigation.
- Misdemeanor conviction of a controlled substance.
- License revocation/suspension or default on a health education loan/scholarship obligation.
- Fraud, kickbacks, and other prohibited activities.
- Entities controlled by a sanctioned individual or individuals controlling a sanctioned entity.
- Exclusion or suspension under a Federal or State health care program.

3.1.2.2. DHHS/OIG authority for permissive exclusions applies where the action (e.g., conviction, license revocation, etc.) took place after August 21, 1996, under Federal or State

law. DHHS/OIG authority does not apply if this condition is not met. In these cases, TMA Program Integrity Office may initiate action to exclude.

3.1.2.3. Permissive exclusions initiated by DHHS/OIG are for no less than one year. Aggravating factors may be considered as a basis for lengthening the period of exclusion.

3.1.3. The contractor is required to provide written notice to TMA Program Integrity Office of any situation involving a TRICARE pharmacy who meets the criteria under the mandatory or permissive exclusion authority granted DHHS/OIG.

3.1.4. TMA Program Integrity Office is responsible for requesting DHHS/OIG initiate mandatory and permissive exclusions of TRICARE pharmacies and will provide appropriate documentation needed to initiate separate sanction action (e.g., indictment, plea agreement, conviction document, sentencing document).

3.1.5. TMA Program Integrity Office will advise DHHS/OIG of TRICARE imposed sanctions and is responsible for supplying DHHS/OIG with the appropriate documentation needed to initiate separate sanction action.

3.2. Notice, Effective Date, Period of Exclusion, and Appeals Process

DHHS/OIG has sole responsibility for issuing a written notice of its intent to exclude a pharmacy or entity, the basis for the exclusion, the effective date, the period of exclusion, and the potential effect of exclusion. DHHS/OIG will handle appeal of exclusions under paragraph 3.0.

3.3. Requests for Reinstatement

DHHS/OIG has sole authority for terminating an exclusion imposed under their authority. DHHS/OIG will handle notifications of approval/denial of a request for reinstatement and are responsible for reversing or vacating decisions.

3.4. Program Notification of Exclusion/Reinstatement

DHHS/OIG exclusions and reinstatements are issued on a monthly basis. DHHS/OIG will provide TMA Program Integrity Office with immediate access to this information via disk, which will then be forwarded to each contractor.

3.5. Scope and Effect of the Exclusion

Exclusions taken by DHHS/OIG are binding on Medicare, Medicaid, and all Federal health care programs. No payment will be made for any item or service furnished on or after the effective date of exclusion until an individual or entity is reinstated by DHHS/OIG, and subsequently meets the requirements under 32 CFR 199.6.

4.0. TMA APPLICATION OF SANCTION AUTHORITY

4.1. Sanction Authority

4.1.1. TMA may exclude any individual or entity based on:

- Civil fraud involving TRICARE.
- Administrative determination of fraud and/or abuse under TRICARE.
- Determination that the pharmacy participated in a conflict of interest situation or received dual compensation.
- Violation of network agreement or reimbursement limitations.
- Administrative determination that it is in the best interests of TRICARE or TRICARE beneficiaries. Examples include unethical or improper practices or unprofessional conduct by a pharmacy; a finding that the pharmacy poses a potential for fraud, abuse, or professional misconduct; the pharmacy poses a potential harm to the financial or health status of TRICARE beneficiaries.

4.1.2. The contractor is required to provide written notice to TMA Program Integrity Office of any situation involving a pharmacy that meets the criteria under the TMA sanction authority.

4.2. Period of Exclusion/Suspension

The Director, TMA or designee, has the authority to exclude or suspend a pharmacy. The period of exclusion is at the discretion of TMA.

4.3. Notice of Exclusion Action

The TMA Program Integrity Office has sole authority for issuing notification of exclusion action. The TMA Program Integrity Office will send written notice of its intent, the basis for the proposed exclusion, and the potential effect of exclusion. The individual or entity may submit evidence and written argument concerning whether the exclusion is warranted. The TMA Program Integrity Office also has sole authority to issue an Initial Determination of Exclusion. Written notice of this decision will include the basis for the exclusion, the length of the exclusion, as well as the effect of the exclusion. The determination also outlines the earliest date on which the TMA Program Integrity Office will consider a request for reinstatement, the requirements for reinstatement, and appeal rights available. The TMA Program Integrity Office will notify appropriate agencies, to include contractors, of all exclusion actions taken. The TMA Program Integrity Office will be responsible for initiating action based on reversed or vacated decisions.

4.4. Effect of the Exclusion

Exclusion of a pharmacy shall be effective 15 calendar days from the date of the Initial Determination. The contractor is responsible for ensuring that no payment is made to a sanctioned pharmacy for care provided on or after the date of the TMA action. The contractor must also ensure that a sanctioned pharmacy is not included in the network and that appropriate steps are taken to notify appropriate parties of exclusion action taken by TMA as outlined in paragraph 5.0.

4.5. Request for Termination of Exclusion

The Director, TMA or designee has sole authority for approval of any request for termination of an exclusion action. TMA Program Integrity Office will consult the contractor concerning any amounts owed prior to reinstatement of an excluded pharmacy.

4.6. Network Pharmacy Termination

Administrative remedies are available to the Director, TMA or designee, as well as contractors, for initiating termination action. TMA Program Integrity Office will terminate any network pharmacy determined not to meet program requirements only in circumstances where exclusion is also warranted. A network pharmacy shall submit a written request for reinstatement to the contractor. The request for reinstatement will be processed under the procedures established for initial requests for network pharmacy status. See Section 6 for further information.

5.0. CONTRACTOR APPLICATION OF SANCTION AUTHORITY

Contractors shall ensure the enforcement of all sanction action taken, notify appropriate parties and its effect upon payment by TRICARE for any pharmaceuticals or supplies provided or received.

5.1. Contractor Actions Under DHHS/OIG Exclusion Authority

5.1.1. The contractor is required to provide written notice to TMA Program Integrity Office of any pharmacy that meets the criteria under the mandatory or permissive exclusion authority granted DHHS/OIG. The notice must include appropriate documentation relevant to the situation (e.g., notice of license revocation, notice of a misdemeanor convictions, etc.).

5.1.2. The contractor will be provided immediate access to the monthly issuance of DHHS/OIG exclusion and reinstatement actions and is responsible for:

5.1.2.1. Ensuring that no payment is made to a sanctioned network pharmacy for care provided on or after the date of the DHHS/OIG action. Neither the network pharmacy nor the patient will be entitled to TRICARE cost-sharing once the exclusion is effective. The contractor must notify TMA Program Integrity Office should a network pharmacy attempt to bill the program after the effective date of exclusion. It will not be necessary for the contractor to issue a separate letter notifying the network pharmacy of the sanction action.

5.1.2.2. Ensuring that a sanctioned pharmacy is not included in the network. If cancellation of a network agreement is required, the contractor shall ensure that the network pharmacy whose contract has been cancelled clearly understands its status. This shall be accomplished by providing notice, by certified mail, return receipt requested, that the network pharmacy's agreement has been cancelled.

5.1.2.3. Issuing a special beneficiary notice (Figure A-8) for claims having a date of service following the effective date of the DHHS/OIG exclusion.

5.1.2.4. Initiating appropriate reinstatement action. DHHS/OIG will advise on the monthly listing if and when a previously sanctioned pharmacy is reinstated. That is the date

that the contractor is to use for reinstatement. The contractor does not need to advise the pharmacy of the reinstatement by DHHS/OIG, but will be responsible for ensuring that the pharmacy meets the regulatory requirements to be reinstated as a network pharmacy. See Section 6, Pharmacy Reinstatements, for additional guidance. The same agencies originally advised of sanction shall also be notified of the reinstatement.

5.2. Contractor Actions Under TRICARE Exclusion Authority

5.2.1. The contractor is required to provide written notice to TMA Program Integrity Office of any pharmacy who meets the criteria under the exclusion authority granted TRICARE. The notice must include appropriate documentation relevant to the situation (e.g., pharmacy poses unreasonable potential for fraud).

5.2.2. The contractor will be notified immediately of an exclusion action taken by the TMA Program Integrity Office and is responsible for:

5.2.2.1. Ensuring that no payment is made to a sanctioned pharmacy for care provided on or after the date of the TMA action. Neither the pharmacy nor the patient will be entitled to TRICARE cost-sharing once the exclusion is effective. The contractor must notify TMA Program Integrity Office should a pharmacy attempt to bill the program after the effective date of exclusion. It will not be necessary for the contractor to issue a separate letter notifying the pharmacy of the sanction action.

5.2.2.2. Ensuring that a sanctioned pharmacy is not included in the network. If cancellation of a network pharmacy agreement is required, the contractor shall ensure that the network pharmacy whose contract has been cancelled clearly understands its status. This shall be accomplished by providing notice, by certified mail, return receipt requested, that the network pharmacy's agreement has been cancelled.

5.2.2.3. Issuing a special notice to any beneficiary who submits a claim or for whom a claim is submitted, which includes services involving a sanctioned pharmacy. The notice may be by letter. The substance of the message should be similar to the example shown under Figure A-8.

5.2.2.4. Initiating appropriate action, as instructed, following reversed or vacated decisions issued by the TMA Program Integrity Office or termination of sanction action by TMA. The same agencies originally advised of sanction shall also be notified of the reinstatement.

5.3. Contractor Requirements For Terminating a Network Pharmacy

When a pharmacy's status as a network pharmacy is ended, the contractor will initiate termination action based on a finding that the pharmacy does not meet the qualifications to be a network pharmacy.

NOTE: Separate termination action by the contractor will not be required for a pharmacy sanctioned under the exclusion authority granted DHHS/OIG.

5.3.1. Period Of Termination

The period of termination will be indefinite and will end only after the pharmacy has successfully met the established qualifications for network pharmacy status under TRICARE and has been reinstated under TRICARE.

5.3.2. Notice Of Proposed Action To Terminate

The contractor shall notify the pharmacy in writing of the proposed action to terminate the pharmacy status as a network pharmacy when the pharmacy is not in compliance with the network agreement, and the pharmacy fails to meet the requirements of 32 CFR 199.6 (Figure A-9).

5.3.2.1. The notice shall state that the pharmacy will be terminated as of the effective date of the sanction action. The notice shall also inform the pharmacy of the situation(s) or action(s) which form the basis for the proposed termination.

5.3.2.2. For network pharmacy, the notice shall inform the pharmacy that beneficiary prescriptions may not be filled there and any claims submitted will be denied as not part of the network.

5.3.2.3. The notice shall offer the pharmacy an opportunity to respond within 30 days from the date of the notice. An extension to 60 days may be granted if a written request is received during the 30 days showing good cause. The pharmacy may respond with either documentary evidence and written argument contesting the proposed action or a written request to present in person evidence or argument to a contractor's designee at the contractor's location. Expenses incurred by the pharmacy are the responsibility of the pharmacy.

5.3.2.4. Once the notice of proposed action to terminate is sent, the pharmacy's claims will not be processed as network claims until an Initial Determination is issued. The pharmacy will be notified via the notice that the claims will not be processed as network claims. Beneficiaries will be advised by the pharmacy that it is no longer a network pharmacy and that any prescription filled there will require submittal of a claim for reimbursement by the beneficiary.

5.3.3. Initial Determination

If after the pharmacy has exhausted, or failed to comply with the procedures for appealing the proposed termination, and the decision to terminate remains unchanged, the contractor shall invoke an administrative remedy of termination by issuing a written notice of the Initial Determination via certified mail. A copy of the Initial Determination will be sent to TMA Program Integrity Office along with supporting documentation. The Initial Determination shall include:

5.3.3.1. A unique identification number indicating the fiscal year of the Initial Determination, a consecutive number within that fiscal year and the contractor's name. A sample letter is found at Figure A-10.

5.3.3.2. A statement of the sanction being invoked and the effective date of the sanction. The effective date shall be the date the pharmacy no longer meets the regulatory requirements. If there is no documentation the pharmacy ever met the requirements, the effective date will be the date on which the pharmacy first became part of the network.

5.3.3.3. A statement of the facts, circumstances, and / or actions that forms the basis for the termination and a discussion of any information submitted by the pharmacy relevant to the termination.

5.3.3.4. A statement of the pharmacy's right to appeal.

5.3.3.5. The requirements and procedures for reinstatement.

5.3.4. Requirement To Recoup Erroneous Payments

After the Initial Determination has been sent, the contractor shall initiate recoupment from the pharmacy for any previously paid claims for pharmaceuticals or supplies furnished by the pharmacy on or after the effective date of termination, even when the effective date is retroactive, unless a specified exception is provided by 32 CFR 199. This applies to claims processed by previous contractors as well. All monies paid by previous contractors and recouped by the current contractor will be refunded to TMA Finance and Accounting Office. Refer to Section G of the contract.

5.3.5. Cancellation Of Network Pharmacy Agreements

The contractor shall ensure that a network pharmacy whose contract has been cancelled clearly understands its status, and shall initiate termination action if required. This shall be accomplished by providing notice, by certified mail, return receipt requested, that the network pharmacy's agreement has been cancelled.

5.4. File Requirements For A Terminated Pharmacy

The Initial Determination file shall only include documentation that is releasable to the pharmacy. This file should also include:

5.4.1. Initial Determination of Termination Action as well as Proposed Notice to Terminate.

5.4.2. Pharmacy Network Agreement.

5.4.3. All correspondence and documentation relating to the termination. Copies of the enclosures must be attached to the copy of the original correspondence.

5.4.4. Documentation that the contractor considered or relied upon in issuing a Determination.

SECTION 6

PHARMACY REINSTATEMENTS

1.0. THIS PARAGRAPH APPLIES TO PHARMACIES SANCTIONED BY TRICARE

For pharmacies sanctioned by DHHS, see Section 6, paragraph 4.0. provisions for reinstating pharmacies previously excluded, suspended, or terminated.

32 CFR 199.9 provides that the Director, TMA, or a designee, shall have the authority to reinstate pharmacies previously terminated, excluded, or suspended under TRICARE. Reinstatement requests from all pharmacies listed in 32 CFR 199.6, shall be submitted to the TRICARE Management Activity (TMA) Program Integrity Office.

2.0. CONTRACTOR RESPONSIBILITIES FOLLOWING REQUESTS FOR REINSTATEMENT FROM TERMINATED PHARMACIES

This pertains to pharmacies previously terminated by the contractor or TMA for failing to meet the requirements of a network pharmacy. The contractor shall first verify that the pharmacy currently meets the requirements of a network pharmacy. If so, and no funds have been paid for services by the pharmacy while terminated or are otherwise owed the Government for claims paid prior to the termination, the contractor may reinstate the pharmacy.

NOTE: This does not include those pharmacies who have been terminated by the TMA based on a fraud case. The contractor shall submit these pharmacy reinstatement requests to the TMA Program Integrity Office.

3.0. CONTRACTOR RESPONSIBILITIES FOLLOWING REQUESTS FOR REINSTATEMENT FROM EXCLUDED OR SUSPENDED PHARMACIES SANCTIONED BY TMA

3.1. For quality of care issues, a request for reinstatement will be sent by TMA to the contractors. For all others, appropriate action should be taken upon receipt of the DHHS reinstatement list.

3.2. The contractor verifies that the pharmacy has all required state licenses necessary to operate as a pharmacy. The exclusion or suspension remains in effect until the contractor has determined that the pharmacy has obtained the required state licenses.

3.3. If the pharmacy has met the state licensing requirements, the contractor shall advise the pharmacy of the date it is eligible to negotiate a new network agreement with the contractor, as determined by the DHHS.

3.4. If the pharmacy does not have the required state licenses, the contractor shall advise the pharmacy as to why it is not eligible to be a network pharmacy and offer appeal rights. A copy of the letter shall be provided to the TMA Program Integrity Office.

4.0. DHHS REINSTATEMENTS

4.1. The contractor must verify that the pharmacy has all required state licenses.

4.2. The contractor may then negotiate a new network agreement with the pharmacy.

SECTION 7

THREATS AGAINST CONTRACTORS

1.0. TERRORIST THREATS

The contractor shall immediately report all terrorist threats to the local police authorities. A written report shall be completed by the individual receiving the threat and sent to the Defense Criminal Investigative Service (DCIS) office having jurisdiction over the area where the threat was initiated or act was stated to occur. This includes all threats against person or property. The contractor shall provide a report of the threat to the TRICARE Management Activity (TMA) Program Integrity Office, giving as much information as possible, within five working days of the threat.

2.0. FREE COMMERCE INTERFERENCE

The contractor shall report any efforts by individuals or professional organizations to exert undue influence through coercion or other inappropriate behavior, on a pharmacy to prevent such pharmacy from joining a pharmacy network, or any effort designed to interfere with free commerce, to the TMA Program Integrity Office within 30 days of learning of such efforts. Supporting documentation should be included with the report.
PROGRAM INTEGRITY

ADDENDUM A

FIGURES

FIGURE A-1 TRICARE FRAUD AND ABUSE REPORT, TMA FORM 435

TRICARE FRAUD AND ABUSE REPORT

ACTION OFFICER

KEYWORD (Region #)	**CONTRACTOR CODE**	**STATE (USPS CODE)**	**DATE REFERRED TO TMA**	
SUBJECT	**NAME (Last, First, MI)**		**SSAN/EIN/TIN**	**ADDRESS (City, State)**
	CROSS REFERENCE (Last, First, MI)			

SECTION (A) POTENTIAL FRAUD OR ABUSE ISSUE (NO MORE THAN 4 SELECTIONS)

POTENTIAL ABUSE

(257) ___ OVERUTILIZATION
(273) ___ QUALITY OF CARE
(282) ___ SERVICES NOT MEDICALLY NECESSARY
(298) ___ WAIVER OF BENEFICIARY COST-SHARE
(299) ___ IMPROPER BILLING PRACTICES
(385) ___ OTHER (Abuse)_____

Was case identified using Artificial Intelligence?

_____ *Yes*

_____ *No*

POTENTIAL FRAUD

(200) ___ MISREPRESENTATION OF CREDENTIALS
(206) ___ ALTERING BILLS/RECEIPTS
(389) ___ BALANCE BILLING LIMITATION
(209) ___ BREACH OF PROVIDER PARTICIPATION AGREEMENT
(211) ___ BILLING FOR SERVICES NOT RENDERED
(230) ___ ELIGIBILITY
(231) ___ EMBEZZLEMENT
(235) ___ FALSIFYING RECORDS/DOCUMENTS
(237) ___ FORGERY OF CHECK
(244) ___ KICKBACKS/REBATES
(248) ___ MISREPRESENTING SERVICES/DIAGNOSES
(256) ___ FAILURE TO DISCLOSE OTHER HEALTH INSURANCE
(386) ___ MISREPRESENTATION OF PATIENT
(387) ___ MISREPRESENTATION OF PROVIDER
(384) ___ OTHER (Fraud)_____

SECTION (B) CLASSIFICATION OF SUBJECT (Check One)

(101) ___ BENEFICIARY
(120) ___ CONTRACTOR EMPLOYEE

PHYSICIAN

(102) ___ GENERAL PRACTICE
(103) ___ SURGEON
(104) ___ PSYCHIATRIST
(105) ___ OBSTETRICIAN
(106) ___ INTERNAL MEDICINE
(108) ___ DENTIST
(112) ___ ANESTHESIOLOGY
(133) ___ OTHER (Physician) Specify)_____

HOSPITAL

(110) ___ ACUTE GENERAL
(111) ___ PSYCHIATRIC
(113) ___ RESIDENTIAL TREATMENT CENTER
(114) ___ SPECIALIZED TREATMENT FACILITY
(107) ___ PSYCHOLOGIST
(109) ___ PODIATRIST
(115) ___ CLINIC, GROUP PRACTICE
(116) ___ LABORATORY
(117) ___ MEDICAL SUPPLIER
(118) ___ AMBULANCE SERVICE
(119) ___ PHARMACY
(121) ___ CLINICAL SOCIAL WORKER
(122) ___ MARRIAGE & FAMILY COUNSELOR
(129) ___ MENTAL HEALTH COUNSELOR
(130) ___ OTHER (Specify)_____
(131) ___ OTHER (Hospital) (Specify)_____
(134) ___ REGISTERED NURSE
(135) ___ OCCUPATION/PHYSICAL THERAPIST
(140) ___ PARTNERSHIP PHYSICIAN
(141) ___ OTHER (Specify)_____

SECTION (C) REFERRAL SOURCE (Check One)

(01) ___ BENEFICIARY/SPONSOR
(02) ___ CONTRACTOR
(03) ___ LEAD AGENT (Region_____)
(05) ___ HEALTH BENEFITS ADVISOR
(06) ___ PROVIDER OF CARE
(08) ___ MEDIA
(09) ___ DEFENSE ELIGIBITY ENROLLMENT REPORTING SYSTEM
(10) ___ TMA/OCHAMPUS PROGRAM INTEGRITY BRANCH
(12) ___ OTHER (FI) (Specify)_____
(13) ___ OTHER GOVERNMENT SOURCE (Specify)_____
(14) ___ QUI TAM
(15) ___ DEFENSE CRIMINAL INVESTIGATIVE SERVICE (DCIS)

SECTION (D) CASE DISPOSITION (Check One)

(PR) ___ PLACED ON PREPAYMENT REVIEW
(PC) ___ PROVIDER CONSULTATION
(MR) ___ REFERRED TO MEDICAL REVIEW
(IG) ___ REFERRED TO DOD IG
(CD) ___ CASE DISMISSED
(RL) ___ REFERRED TO LICENSING BOARD
(TR) ___ TRANSFERRED
(DI) ___ REFERRED TO TMA/CHAMPUS PROGRAM INTEGRITY
(DP) ___ DENIED PAYMENT
(RF) ___ RECOUPED FUNDS
(FR) ___ REFERRED TO CONTRACTORS RECOUPMENT SECTION
(LT) ___ REFERRED TO TMA/OCHAMPUS RECOUPMENT SECTION
(NC) ___ NOT CHASED (Conviction, but for hardship reason no recoupment)
(PS) ___ PROVIDER SANCTIONED (Terminated or Excluded)

SECTION (E) DOLLAR IMPACT	(01) DOLLARS CURRENT CASE	(02) DOLLARS IDENTIFIED FOR RECOUPMENT	(03) DOLLARS RECOUPED

TMA/OCHAMPUS FORM 435 **PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE**
JAN 2002

INSTRUCTIONS

This form is to be completed for each potential fraud or abuse case opened.

FIGURE A-1 TRICARE FRAUD AND ABUSE REPORT, TMA FORM 435 (CONTINUED)

A. Fraud or Abuse Issue: May select up to four issues. If more than one applies, rate them from most to least important.

B. Classification of Subject: Self-explanatory. Check the category which most appropriately identified the subject.

C. Referral Source: Select the one which most appropriately identifies the referral of this case.

D. Case Disposition: Select the one which most appropriately identifies the disposition of this case. Do not complete if referred to TMA, Program Integrity Office.

E. Dollar Impact: Complete (01) Dollars Current Case, i.e., erroneous or overpayment amount, when referred to TMA, Program Integrity Office.

FIGURE A-2 SAMPLE LETTER TO BENEFICIARY IN EXTERNAL AUDIT CASES

(Beneficiary Address)

Dear_____:

We are pleased that we were recently of service to you. Now we ask your participation in this survey to help us improve service to you and all other TRICARE beneficiaries. We are requesting that you review the following information to determine whether our records are correct. Our records show that you received the following services:

Pharmacy: *(Name of Pharmacy)*

Date of Service: *(List by each date of service. Do not use range dates.)*

Place of Service:

Type of Service: *(List by narrative description, not by procedure code.)*

Amount Billed to Patient:

Amount Paid by Patient, Sponsor, or Parent/Guardian:

Cost-share Amount or Other Health Insurance Amount:

If the "amount paid by patient" was not actually paid to the pharmacy by the patient, sponsor, or parent/guardian, explain below or on the reverse side of this letter.

Please circle any of the above items which appear to be wrong and explain on the reverse side of this letter. In addition, please provide the following information:

Did you sign a claim form or an authorization form supplied by the pharmacy for the pharmaceuticals or supplies shown above? YES _____, NO _____.

Did you sign a "benefit assignment" form which stated you were responsible for the full charges over and above what your insurance (or TRICARE) would pay? YES_____ NO _____.

Your work phone number: _____ Home phone number: _____,

We appreciate your assistance in responding to this request and have enclosed a self-addressed stamped envelope for your convenience. If you have any questions, please call (*Telephone Number*). Thank you for your cooperation.

Sincerely,

Name, Title and Office

Enclosure:
Self-Addressed Stamped Envelope

FIGURE A-3 SAMPLE LETTER TO PHARMACY IN EXTERNAL AUDIT CASES

(Pharmacy Address)

Dear_____:

Recently, we received a claim filed by a beneficiary who reported pharmaceuticals and/or supplies furnished by you. Now we ask your assistance in this survey to help us improve service and benefits to all TRICARE beneficiaries and pharmacies. Please review the following information in your records to determine whether our information is correct.

Patient Name:

Sponsor SSN:

Date of Service:

Place of Service:

Type of Service:

Total Amount Billed Patient:

Please circle any of the above items which appear to be in error, provide the correct information next to it, and return this letter in the enclosed self-addressed, stamped envelope. If the information is correct, write the word "correct" on this letter and return it.

In addition, please provide the following information:

1. Procedure, diagnosis or additional description of services provided this patient:
2. Your telephone number:

Thank you for your attention to this matter. Your assistance in responding to this survey is appreciated.

Sincerely,

Name, Title and Office

Enclosure:
Self-Addressed Stamped Envelope

FIGURE A-4 SPECIAL NOTICE TO NETWORK PHARMACY WHEN THE PHARMACY'S CLAIMS ARE SUSPENDED (SAMPLE)

(Pharmacy Address)

Dear_____:

This is to inform you that we have been notified by the TRICARE Management Activity (TMA) to suspend payment for present and future claims for services provided by you or your organization. This action is being taken immediately under the provisions of the 32 Code of Federal Regulations 199.9 because of further investigation by the Government of your organization's medical and/or financial records. This suspension is for an indefinite period of time as determined by TMA.

Please note that any participation agreement with your patients remains in full force and effect and you cannot repudiate the agreement as a result of the delay in final disposition of the claims. The assessment of a finance charge, either to the beneficiary or the Government, on these suspended claims is also prohibited.

Within 30 days of the date of this notice, you may present to the Chief, Program Integrity Office, TMA, in writing, information (including documentary evidence) and argument in opposition to the suspension, provided the additional specific information raises a genuine dispute over the material facts, or you may submit a written request to present in person, evidence to the Director, TMA, or a designee. All such presentations shall be made at TMA, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066 at your expense.

If you have any questions or comments concerning this action, we suggest you convey them in writing to this address:

(Contractor's Address)

Sincerely,

Name, Title and Office

NOTE TO CONTRACTOR

The TMA Program Integrity Office will be the sole authority for the direction of issuance of a notice of the suspension of a pharmacy's claims from processing. Instructions will be provided on an individual case-by-case basis. The contractor shall state the reason for the claims processing suspension provided by TMA.

FIGURE A-5 SPECIAL NOTICE TO BENEFICIARY WHEN THE BENEFICIARY'S CLAIMS ARE SUSPENDED DUE TO POSSIBLE BENEFICIARY FRAUD (SAMPLE)

(Beneficiary Address)

Dear_____:

This is to inform you that your claims have been suspended pending review by the TRICARE Management Activity (TMA), effective *(Date)* for an indefinite period of time. This action is being taken by the TMA under the provisions of the 32 Code of Federal Regulation 199.9, because of further investigation by the Government of your claims.

Within 30 days of the date of this notice, you may present to the Chief, Program Integrity Office, TMA, in writing, information (including documentary evidence) and argument in opposition to the suspension, provided the additional specific information raises a genuine dispute over the material facts or you may submit a written request to present, in person, evidence to the Director, TMA, or a designee. All such presentations shall be made at TMA, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066, at your expense.

If you have any questions or comments concerning this action, we suggest you convey them in writing to this address:

(Contractor's Address)

Sincerely,

Name, Title and Office

NOTE TO CONTRACTOR

The TMA Program Integrity Office will be the sole authority for the direction of issuance of a notice of the suspension of a pharmacy's claims from processing. Instructions will be provided on an individual case-by-case basis. The contractor shall state the reason for the claims processing suspension provided by TMA.

FIGURE A-6 SPECIAL NOTICE TO BENEFICIARY WHEN A BENEFICIARY'S CLAIMS ARE SUSPENDED DUE TO POSSIBLE PHARMACY FRAUD (SAMPLE)

(Beneficiary Address)

Dear_____:

This is to inform you that your claim(s) for services provided by ***(Pharmacy's Name and Address)*** has been suspended pending review by the TRICARE Management Activity (TMA), for an indefinite period of time. This action is being taken by the TMA under the provisions of the 32 Code of Federal Regulations 199.9, because of further review by the Government of services/supplies provided by ***(Name of Pharmacy)***.

If you have any questions or comments concerning this action, we suggest you convey them in writing to this address:

(Contractor's Address)

Sincerely,

Name, Title and Office

NOTE TO CONTRACTOR

The TMA Program Integrity Office will be the sole authority for the direction of issuance of a notice of the suspension of a pharmacy's claims from processing. Instructions will be provided on an individual case-by-case basis. The contractor shall state the reason for the claims processing suspension provided by TMA.

FIGURE A-7 NOTICE TO PHARMACY EXCLUDED OR SUSPENDED UNDER THE SOCIAL SECURITY ACT (SAMPLE)

(Pharmacy Address)

Dear_____:

The Department of Defense, TRICARE Management Activity (TMA), has been advised by the Department of Health and Human Services (DHHS) that you have been *(Excluded* or *Suspended)* from Medicare participation under the provisions of the Social Security Act. This *(Exclusion* or *Suspension)* for the period *(Insert Terms of Sanction, i.e., One Year, Two Years, etc.),* was effective 15 days from the date of DHHS' notice of *(Insert Date of DHHS' Notice)* and will remain in effect for the period of time determined by the Secretary of the Department of Health and Human Services.

Based on the provisions of the regulation governing the operations of TRICARE, 32 CFR 199.9, payments under TRICARE will also be denied for services or supplies furnished 15 days after the date of this letter. As the actions taken by TRICARE are based on a DHHS determination, no administrative appeal rights are available under 32 CFR 199.10 which specifically provides that:

> "Any sanction, including the period of the sanction, imposed under Chapter 9 of this Regulation which is based solely on a pharmacy's exclusion or suspension by another agency of the Federal Government, a state, or a local licensing authority is not appealable under this chapter. The pharmacy must exhaust administrative appeal rights offered by the other agency that made the initial determination to exclude or suspend the pharmacy."

If you wish to provide services under TRICARE after you are reinstated by DHHS, you must apply for reinstatement to the Chief, Program Integrity Office, TMA, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066. Include a copy of your DHHS reinstatement letter and documentation sufficient to establish that you meet the qualifications under the Regulation to be a network pharmacy.

Sincerely,

Name, Title and Office

cc:
Program Integrity Office
TMA

NOTE TO CONTRACTOR

Letter is to be sent by Return Receipt Requested or any other method requiring a signature documenting receipt.

FIGURE A-8 NOTICE TO BENEFICIARY WHEN PHARMACY IS EXCLUDED OR SUSPENDED UNDER THE SOCIAL SECURITY ACT (SAMPLE)

(Beneficiary Address)

Dear_____:

This is to inform you that (*Name of Pharmacy)* has been *(Excluded* or *Suspended)* as an authorized pharmacy under the TRICARE Management Activity (TMA) effective *(Give Actual TRICARE Effective Date).* This action is being taken by the TMA based upon a Department of Health and Human Services *(Exclusion* or *Suspension)* under the provisions of the Social Security Act and the 32 Code of Federal Regulations 199.9. Therefore, we will not pay for any services provided to you by *(Name of Pharmacy),* on or after *(Actual TMA Effective Date)* for a period of time determined by TMA. The pharmacy has been notified by the Department of Health and Human Services and TMA of this action.

If you need assistance in selecting an alternative pharmacy, please contact your Beneficiary Counseling and Assistance Coordinator (BCAC) or call *(Give Appropriate Contractor Telephone Number).*

Sincerely,

Name, Title and Office

FIGURE A-9 NOTICE OF PROPOSED ACTION TERMINATING A NETWORK PHARMACY (SAMPLE)

(Pharmacy Address)

Dear_____:

This is to notify you of our proposed action to terminate you as a TRICARE network pharmacy. This decision is based on the fact that you do not meet the qualifications as a TRICARE network pharmacy as established by the 32 Code of Federal Regulations 199.6, based on the documentation submitted to us. (*NOTE: The contractor shall give the reasons and supporting facts for the proposed termination.*)

The effective date of this termination is retroactive to (*Insert Date* and *provide one of the following statements: The date on which you did not meet these requirements, or June 10, 1977, the effective date of the Regulation, WHICHEVER DATE IS LATER*). The period of termination is indefinite and will end only after you have successfully met the established qualifications for network pharmacy status under TRICARE.

Authority for this termination can be found in the 32 Code of Federal Regulations 199.9, which provides administrative remedies for fraud, abuse and conflict of interest, and for termination when the network pharmacy has not met or satisfied the criteria for TRICARE network pharmacy status. Since a pharmacy is expected to know the TRICARE requirements for qualification as a network pharmacy, and we have no evidence that you meet the qualification requirements, you are considered to have forfeited or waived any right or entitlement to bill the beneficiary for the care involved in the TRICARE claims. If you do bill the beneficiary, restitution to the beneficiary may be required by the Director, TMA, or a designee, as a condition for consideration of reinstatement as a TRICARE network pharmacy. Beneficiaries who choose to continue to use the services of an unauthorized TRICARE pharmacy shall not be reimbursed by TRICARE.

The retroactive effective date of termination shall not be limited due to the passage of time, erroneous payment of claims, or any other events which may be cited as a basis for TRICARE recognition of the pharmacy, notwithstanding the fact that the pharmacy does not meet program qualification requirements. Unless specific provision is made to "grandfather" or authorize a network pharmacy who does not otherwise meet the qualifications established in the 32 Code of Federal Regulations 199.6 all unqualified network pharmacies shall be terminated.

Any claims cost-shared or paid under TRICARE for services or supplies furnished by the pharmacy on or after the effective date of termination, even when the effective date is retroactive, shall be deemed an erroneous payment. All erroneous payments are subject to collection. Any further claims processing will be suspended unless you provide documentation that you meet the requirements as a network pharmacy.

We will consider any documentary evidence or written argument regarding the proposed action submitted within 30 days of the date of this letter. You may also submit within 30 days a written request to present in person, evidence or argument to *(Insert Unit* or *Name Of Person And Address To Whom The Pharmacy Is To Submit Certification Documentation*). All such presentations shall be made at the above mentioned office at your expense.

FIGURE A-9 NOTICE OF PROPOSED ACTION TERMINATING A NETWORK PHARMACY (SAMPLE)

Any requests or submittals to *(Insert Unit or Person's Name Mentioned Above)*, must be received within 30 days of the date of this letter or, if received after 30 days, must be postmarked within 30 days of the date of this letter. If you cannot present additional information within 30 days, upon written request and for good cause shown, you may request that additional information be submitted within 60 days from the date of this letter. All communications with this office should be in writing.

Sincerely,

Name, Title and Office

NOTE TO CONTRACTOR

This letter is to be sent by Return Receipt Requested or any other method which will document receipt.

FIGURE A-10

REPORTING PERIOD ENDED _____,

The TRICARE Fraud and Abuse Case Report, TMA Form 435, will be completed on every case opened for initial investigation of potential fraud or abuse. The following information, which is essentially the same as on Form 435, will be submitted to the Program Integrity Office, TRICARE Management Activity (TMA), within 45 days of the last day of each calendar quarter.

A. Case Workload Report

Number of open pending cases beginning of quarter	
Add-number of new cases opened during quarter (Opened Case: A case requiring special review for possible fraud or abuse)	+
Less-number of cases closed during quarter (Closed Case: A case for which the potential fraud or abuse issue has been resolved and final action has been taken)	-
Equals number of cases pending end of quarter	
Number of cases referred to the TMA Program Integrity Office during quarter	
Total number of pending cases at the TMA Program Integrity Office	

B. Categorical Information on Cases Closed During this Quarter

CLASSIFICATION OF SUBJECT	NUMBER OF CASES
Beneficiary	
Physician	
General Practice	
Surgeon	
Psychiatrist	
Obstetrician	
Internal Medicine	
Anesthesiologist	
Dentist	
Other (Specify)	
Psychologist	
Podiatrist	
Hospital	
Acute General	
Psychiatric	
Other (Specify)	
Skilled Nursing Facility	
Residential Treatment Center	
Specialized Treatment Facility	

FIGURE A-10

REPORTING PERIOD ENDED _____,		
Clinic, Group Practice		
Laboratory		
Medical Supplier		
Ambulance Service		
Registered Nurse		
Clinical Social Worker		
Marriage, Family and Pastoral Counselor		
Mental Health Counselor		
Chiropractor		
Occupational Therapist		
Physical Therapist		
Others		
Total		

POTENTIAL FRAUD OR ABUSE ISSUES--REPORT MANAGED CARE & TRICARE SEPARATELY, AS FOLLOWS

ISSUE - POTENTIAL ABUSE	*NUMBER OF CASES*	*TOTAL DOLLAR AMOUNT BY ISSUE*
Waiver of beneficiary cost-shares		*$*
Improper billing practices		*$*
Services Not Medically Necessary		*$*
Overutilization		*$*
Failure to File Claims (Provider)		*$*
Billing Administrative Charge for Filing Claims		*$*
Quality of Care		*$*
Other (Specify)		*$*

ISSUE -- POTENTIAL FRAUD -- REPORT AS FOLLOWS	*NUMBER OF CASES*	*TOTAL DOLLAR AMOUNT BY ISSUE*
Billing for Services Not Rendered		*$*
Misrepresenting Services / Diagnosis		*$*
Altering Bill / Receipt		*$*
Falsifying Records / Documents		*$*
Kickbacks / Rebates		*$*
Eligibility		*$*
Embezzlement		*$*
Forgery of Check		*$*
Other Health Insurance		*$*

FIGURE A-10

REPORTING PERIOD ENDED _____,	
Misrepresentation of Credentials	*$*
Breach of Provider Participation Agreement	*$*
Balance Billing Limitation	*$*
Misrepresenting Patient	*$*
Misrepresenting Provider	*$*
Other (Specify)	*$*
Total	*$*
FRAUD OR ABUSE REFERRAL SOURCE -- REPORT AS FOLLOWS	*NUMBER OF CASES*
Beneficiary / Sponsor	
Clerical Identification	
Prepayment Review	
Postpayment Review	
Health Benefits Advisor	
Provider of Care	
Medical Review (Third Level)	
Media	
DEERS	
TMA	
DCIS	
Other Contractor	
OHI	
Public / anonymous	
Other (Specify)	
DISPOSITION OF FRAUD AND ABUSE CASES -- REPORT AS FOLLOWS	*NUMBER OF CASES*
Place on Prepayment Review	
Provider Consultation	
Referred for Medical Review	
Referred to the TMA Program Integrity Office	
Case dismissed (no issue)	
Referred to Licensing Board	
Denied Payment	
Recouped Funds	
Referred to Contractor Recoupment Section	
Referred to the TMA Recoupment Section	
Provider Sanctioned (terminated or excluded)	
Other (specify)	

FIGURE A-10

REPORTING PERIOD ENDED _____,	
DOLLAR AMOUNT REPORT	*DOLLAR AMOUNT*
Actual monies saved this quarter:	*$*
Recoupments	*$*
Claim Denials (Partial and Full)	*$*

RECOUPMENT ACTION				
BENEFICIARY/PROVIDER NAME	*SSN/EIN*	*REQUESTED RECOUPMENT*	*RECEIVED THIS QUARTER*	*RECEIVED TO DATE*
		$	$	$
		$	$	$
		$	$	$
		$	$	$